A HISTORICAL SURVEY OF PSYCHIATRIC PRACTICE IN GHANA

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Psychiatry in Ghana is of recent origin. Prior to 1951, there were no psychiatrists in the country, except for a brief period in 1929, when Dr. Maclagan D.P.M., was appointed alienist to the Asylum at Accra, a position he held for a short time before his transfer to head office.

In the very early days when mental patients began to be segregated, they were kept in prisons, as in other parts of Africa (Margetts, E. L.; Ordia, A; Raman, A.C.; 1958)

The background of Psychiatric Practice

The first African Psychiatrist appeared on the mental health scene in Africa, south of the Sahara in 1951, and was posted to the then Gold Coast, to the mental hospital at Accra. Prior to his appointment the need for the establishment of some form of scientific treatment for the mentally sick, and an appraisal of the extent and distribution of mental illness in the country, had been felt.

In 1946, Dr. G. Tooth came out to the Gold Coast from the United Kingdom, and conducted a survey, the result of which awakened some interest in the Government of the day, to embark on a programme to improve the lot of the mentally disordered patients.

For nine years, there was only one psychiatrist in the country. About this period too, there were only four African Psychiatrists on the continent, one in Nigeria, and two in the Sudan. This paucity of Specialists in this field reflected the general attitude of the African toward psychiatry, and the importance placed on this branch of medicine which, locally had been shrouded in withchraft, juju, taboos, religious cults, fetish and Zar (Leivis, M. 1958) influences.

It was felt that the local treatment facilities at the hands of fetish priests, native doctors and other charlatans, were adequate to cope with the situation. Particularly as some of the patients were regarded as being in a state of religious possession and were to be revered. Those who, unfortunately were regarded as agents of demons, then deserved whatever fate lay in wait for them, because they were being punished for their sins. This has been the turbulent sea in the midst of which psychiatry had tried to raise its critical head. This also explains the reluctance of the young medical officer to take up the speciality. Some doctors have sought reassurance that constant association with the mentally ill patients was not in itself conducive to a breakdown.

There has been a slow and gradual change of heart towards psychiatry in Africa, and now a number of Africans are in training in the United Kingdom, Canada and elsewhere. The attitude of the general population is also undergoing a gradual change and the so-called western method of treatment is being given a fair chance. This is reflected in the number of people now seeking treatment as voluntary patients. In 1960 there were 317 such patients in hospital compared with 1951 when there was none. This attitude however, does not mean that the native doctors and others, have ceased to function. They still carry on their several practices, but do not now enjoy the monopoly of having the first chance with the patient, leaving the hospital to deal with their failures (Smart, C.G.F., 1958; Lambo, T.A., 1959)

The function of the fetish priests continues to exist, for after the patient has been discharged from hospital improved, this is regarded as only partial, becoming complete only after the performance of certain customary rites.

The First Lunatic Asylum

On February 4, 1888, by a legislative instrument under the signature of the then Governor, the old High Court at Victoriaborg was converted into the first lunatic asylum in the Gold Coast. Unfortunately, records are not now available to give any information as to the number of patients who were first kept under the new system of custodial segregation. In 1904, we learn that the number of inmates had risen to 104. During 1905, there were

80 patients at the hospital consisting of 61 males and 19 females. Of these, eleven males and three females died, and four males were discharged improved by the end of the year. On the first of January 1906, there were 72 patients in hospital. During the same year, there were 33 new admissions, raising the total patient population to 95, 76 males and 19 females. Fifteen males and four females died during the year, and 13 patients were discharged improved.

The staff of the Asylum at that time consisted of:—

1 Chief Attendant
1 Assistant Chief Attendant
9 Attendants (male)
1 Matron
1 Gate keeper

On the first of January 1907, there were 63 patients in the Asylum.

During these early years, the function of the asylum was purely one of custodial segregation. No treatment was given and the main function of the staff was to supervise the feeding of the patients and report on their physical health to the appropriate authority.

The Present Mental Hospital

During the year 1906, the available accommodation for mental patients was considered inadequate and a new hospital was built on the site of the present Mental Hospital at Accra. The hospital was built of concrete, was well sited just outside the town and was surrounded by good arable land, but owing to a shortage of water the patients were not transferred from the old court building until 1907. The new hospital consisted of an administrative block, a dispensary, an office for the visiting doctor, a store, a gate keeper's room, a night warder's room and a kitchen. In addition there were two large court yards which measured 250 feet by 150 feet, and 131 feet by 150 feet and around these court yards were built the dormitories, wash houses and toilets.

One hundred and ten patients were admitted into the new hospital and they were looked after by sixteen untrained nurses, and a visiting doctor who was also in charge of the prisons. The patients' meals were prepared by the criminal lunatics, under the supervision of the nurses. At this time, some form of treatment which was described as the "exhibition of mind suiting drugs" was apparently given to the patients. These drugs were chiefly arsenicals. The restless and violent patients were restrained by the use of handcuffs and leg irons, or by seclusion in single cells. Patients who were able to work carried on vegetable farming as a form of occupational therapy.

Problem of overcrowding

The Mental Hospital in Accra, was the only one in the entire country and by 1909, only two years after it was opened, it was already catering for 275 patients — more than double the number of patients it was built to accommodate. This problem of overcrowding has continued ever since and to-day, inspite of extensions and additions to the Hospital it is still not solved. The official capacity of the extended hospital is now 600 but there are in fact over 1,800 patients in Accra and another 300 have been transferred to Adomi, where an annexe of the Central Mental Hospital is run as a village settlement. (Table 1.)

Treatment facilities offered

Since 1951 the hospital has lost its purely custodial function and has assumed the role of a therapeutic community where active treatment is given in a humane manner. Restraint is now by purely chemical means, and in addition facilities exist for treatment by means of pharmacotherapy, electroconvulsive therapy, occupational therapy and group psychotherapy. It is possibly these changes which account for the increase in the admission rate. Patients now come to hospital on a voluntary basis, and in 1960, three hundred and seventeen such patients were admitted.

When one takes the entire country into consideration, a single mental hospital for a population of six million, is grossly inadequate. Psychiatric facilities and services are therefore extremely limited. The extent of psychosis in the country is not known and estimations based primarily on mental hospital admissions, are completely inaccurate and misleading. In 1946, Tooth made a survey of mental illness in the Gold Coast and stated that the number of mentally ill patients in hospital, represented only about

TABLE 1. *The actual number of patients in hospital compared with the official capacity of the Mental Hospitals, Accra.* (1946 - 1960).

Year	Total Number of Patients in Hospital	Hospital Built to accommodate	Percentage of overcrowding
1946	653	510	28.0
1947	585	510	14.7
1948	673	510	31.9
1949	689	510	35.1
1950	729	510	42.9
1951	692	530	30.5
1952	736	530	38.8
1953	869	530	63.9
1954	1030	600	71.6
1955	1189	600	98.1
1956	1287	600	114.5
1957	1362 (300 at Adomi)	600	77.0
1958	1495 (300 at Adomi)	600	99.1
1959	1555 (300 at Adomi)	600	109.1
1960	1700 (300 at Adomi)	600	183.3

10 per cent of the total number of insane people in the general population of the country.

In Ghana, there are no special institutions for the mentally defective patient. According to our laws, such a person is classified as a lunatic and subjected to the rules and regulations governing lunatics (Laws of Ghana, 1954). There are no facilities for clinical psychological testing and until recently, no electro-encephalographic studies could be undertaken.

Types of Mental Illness Treated

Table 2 shows the distribution of the new admissions from 1956 to 1960 according to diagnostic labels. The majority of the patients were schizophrenics and they formed 40 per cent of the total admissions in 1956, and 41 per cent in 1960. General paralysis of the insane is a rarity at the Accra Mental Hospital. No cases were seen between 1955 and 1960. Table 2 shows however, a number of cases diagnosed as cerebral or meningo-vascular syphilis with psychotic manifestations. This diagnosis was made, not only from a positive blood Kahn test, but also from the presence of mental symptoms suggesting an organic brain lesion: Intellectual impairment, labile mood, mental confusion in association with various neurological signs, such as ocular palsies, and loss of tendon reflexes. In 1956 only four such cases were diagnosed, and in 1960, only eight such cases were in hospital. This agrees with Smartt's observation from Tanganyika. Tewfik of Uganda however, records an incidence of general paralysis of the insane at 9 per cent of his total cases.

TABLE 2. *Types of Mental Illness treated at the Mental Hospital, Accra.* (1955 - 1960).

Year	Schizophrenia	Manic depressive psychosis	Senile dementia	Primary dementia	Chronic alcoholism	Amentia	Confusional psychosis	Involutional depression	Epilepsy	Feeble mindedness	Syphilis	Unclasified	Total
1955	280	106	27	32	19	15	25	23	142	28	15	477	1189
1956	195	82	13	6	12	7	10	5	19	7	4	71	533
1957	191	90	17	11	7	5	24	10	46	13	3	190	607
1958	108	144	24	19	25	24	30	21	588	11	8	201	673
1959	171	172	24	18	16	37	26	17	366	14	7	193	731
1960	446	162	14	12	18	23	44	19	52	15	8	197	1010

A View Into The Future

The problem of mental health is one of re-educating people in the whole sphere of inter-personal relationships in such a way as to give them insight into their own behaviour and that of others. While early childhood may offer the best opportunities for education it is essential that education should be carried on among people of all ages and walks of life. Manipulation of the environment then becomes the basic prophylactic exercise when one contemplates the introduction or the modification of a mental health programme for a community.

Problems of Industrialisation

In Ghana today, our extensive development programme and industrialization scheme have led to the migration of labour groups from the security and calm of their village environment, to the rush, the stresses and the tensions of the town, in more or less completely foreign cultural areas. Such migrations are motivated by social and economic conditions, and have cultural and political significance. There is an observable increase in the psychopathological conditions where such migrations take place. The greater the difference between the original and the new environment, the greater is the increase in mental disturbance.

It is evident therefore, that the near future would see a rise in mental illness in Ghana as the population is called upon more and more, to make a new adjustment to an ever changing environment; some of these changes strike at the very heart of customs and traditions and also at the social security from which people derive a lot of psychological support. The fact that certain neuroses which do not respond to western therapeutic methods react rapidly and in a satisfactory manner to native psychotherapeutic measures, demonstrates the importance of social values in the domain of psychotherapy.

Mental Hospital Programme

On the practical side it is clear that in order to reduce the period of morbidity to a minimum there must be facilities for early hospitalisation and treatment of patients. To achieve this, a number of small mental hospitals will be built, to house about two hundred and fifty to three hundred patients. These hospitals will be distributed in such a way that every Region will be adequately served. Such an arrangement will remove the unsatisfactory state of affairs whereby patients have to be moved into an entirely new environment for the treatment of a condition which is partly contributed to by maladjustment and unsatisfactory inter-personal relationships.

The Training of Personnel

It is envisaged that in the near future both African Psychiatrists, (i.e. native Africans trained in psychiatry), and non-African Psychiatrists with a good African cultural orientation, will be required to man our psychiatric institutions, and to look after our mentally disturbed patients. The question arises whether these native-African Psychiatrists should be given a specialized training with an African culture bias, or whether the present training which takes place outside Africa is adequate and appropriate? My view is that the present training of Psychiatrists which consists of an indoctrination of the basic principles of psychiatry, divorced from any specified cultural orientation, has much to recommend it. We do not want Psychiatrists who will be parochial in outlook, and ultimately cut off from the rest of global psychiatry, because of differences in methodological format.

We are all aware of the diverse cultural traditions that exist in Africa and how much these vary even in any one country. No homogeneous African culture exists, and to establish a school specifically to take cognisance of this will be difficult. However, it would be to the advantage of psychiatry in future, if training would comprise sessions in anthropology, social psychology and trans-cultural psychiatry. A Psychiatrist who then wishes to practice in a particular country should undergo a six month orientation course in the cultural structures and infrastructures of the country in which he intends to practice. Other staff such as nurses, hospital orderlies etc. should of course be recruited and trained locally.

The future of psychiatry in Ghana is bright, not only because of the proposed improved facilities for the care and treatment of the mentally disturbed, but also because among the population there is now an increasing awareness of the services that psychiatry offers. It may also be expected that the all round improvement in the general health of the population by the provision of good housing, good water supply and adequate food, together with the intensification of

agricultural production and the diversification of industry to minimise migration of wage labour, will contribute a great deal to modify stresses and tensions and thereby reduce the incidence of mental illn ss in Ghana.

Owing to the shortage of Psychiatrists in Africa and the uphill endeavour to establish a good mental health scheme, not only in Ghana but in Africa as a whole, Psychiatrists are in great demand throughout the continent and we in Ghana would welcome assistance in the form of short term attachment to our institutions for the purposes of much needed research into our psychiatric problems.

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